CALIFORNIA HEALTH POLICY STRATEGIES, L.L.C.

Statewide Learning Collaborative to Support Integration of CalAIM and Community Based Dementia Programs

Overview and Level-Setting

August 11, 2023

Introduction

The Archstone Foundation is sponsoring a new statewide learning collaborative to support the integration of CalAIM and community-based dementia related and other programs that serve individuals at high risk of institutionalization. This project is being facilitated by California Health Policy Strategies, a Sacramento-based consulting group.

This memo is intended to outline a common framework for understanding the opportunities under CalAIM and the populations who may be eligible to benefit from CalAIM programs and services. Historically in California, the programs serving the older adult population, including adults with dementia, were limited by funding sources or eligibility or other factors and typically operated outside of the Medi-Cal managed care system. Through CalAIM, such programs are being brought under the operations of the Medi-Cal managed care system to be more integrated and coordinated across the full spectrum of health and support services.

The DHCS CalAIM initiative offers an unprecedented opportunity for engagement and support of high cost Medi-Cal beneficiaries with complex medical and behavioral health needs. The new Enhanced Care Management (ECM) benefit and access to non-clinical Community Supports (CS) are potential game changers that can significantly improve health care outcomes, reduce unnecessary hospitalizations and emergency room visits, and enhance quality of life. CalAIM builds on the state's Medi-Cal managed care program, which is now responsible for delivering health care for most Medi-Cal beneficiaries. The mandatory enrollment of "dual eligible" individuals, who are eligible for both Medicare and Medi-Cal, adds to the potential CalAIM eligible population.

Community-based organizations that currently provide case management and non-clinical services to older Californians with dementia and/or other medical or behavioral health issues are often unfamiliar with Medi-Cal managed care plan culture, practices, policies, and procedures. However, CalAIM's success will depend on how well these CBOs develop relationships and contracts with their local Medi-Cal managed care plans (MCPs). With Medi-Cal beneficiaries overwhelmingly comprised of persons of color, CalAIM also offers an opportunity to address health disparities and health equity in their implementation of new programs and services.

The statewide learning collaborative can facilitate relationship building among CBOs and the MCPs in their counties. This collaborative would lift up the unique needs of older Californians with dementia and/or complex medical conditions, many of whom are dual eligible. It could also become a venue for the identification of common implementation challenges, policy advocacy, best practices, and workforce development. The statewide learning collaborative is being convened to

facilitate engagement with community-based organizations (CBOs) serving the dementia population in California. These organizations will work together to identify barriers and solutions to accessible and effective service delivery and implement CalAIM in their communities. DHCS is openly and continuously focused on systems improvements within the ECM program. One role of the statewide collaborative will be to identify meaningful changes to improve the accessibility of these services.

Recognizing the value of CBOs of that current serve and understand unique population of focus, DHCS has specifically called out categories of organizations that MCPs should be contracting with for the delivery of ECM services. For the "At Risk of Institutionalization" population, DHCS suggests the following organizations:

- Memory care, assisted living, and independent living organizations
- Voluntary Alzheimer's/Dementia Education Organizations (e.g., Alzheimer's Los Angeles or Alzheimer's San Diego)
- CBAS centers
- Area Agencies on Aging
- Home Health Agencies
- Centers for Independent Living

Overview of CalAIM

California Advancing and Innovating Medi-Cal (CalAIM) is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. Led by the Department of Health Care Services (DHCS), CalAIM has three primary goals:

1. Identify and manage comprehensive needs through whole person care approaches and social drivers of health.
2. Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.
3. Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.

DHCS aims to move Medi-Cal towards a population health approach that prioritizes prevention and whole person care, bringing services and supports outside of traditional health care settings into communities to reach people where they are. There are more than a dozen programs and initiatives designed to be implemented across a broad network of partners, including health plans, providers, and community-based organizations. Among the initiatives with the greatest potential to transform care for older adults and persons with disabilities, including those with Alzheimer's Disease and Related Dementias (ADRD) are Enhanced Care Management (ECM) and Community Supports (CS). Paired with Providing Access and Transforming Health (PATH) and Incentive Payment Program (IPP), providers will have access to funding for investment and sustained commitment to CalAIM programs.

CalAIM will change the way care is delivered to many older adults in California served by Medi-Cal or who are dually eligible for Medi-Cal and Medicare (Duals), including:

- Current dual eligible demonstration in seven counties ended and beneficiaries automatically transitioned into a different plan operated by same parent company (Medicare Medi-Cal or Medi-Medi plan)[1]
- Some dual eligible beneficiaries currently in D-SNP look-alike plans transitioned to another Medicare Advantage plan offered by same organization
- Mandatory Medi-Cal managed care enrollment for dual eligible beneficiaries
- Long Term Care (LTC) Carve-In: all Medi-Cal only and dual eligible beneficiaries in Medi-Cal fee-for-service residing in a Skilled Nursing Facility (SNF) enrolled in Medi-Cal managed care
- Populations of Focus in ECM/CS launching encompass many dual eligibles
- Medi-Cal expansion for adults 50 and older regardless of immigration status

Enhanced Care Management (ECM)

Enhanced Care Management (ECM) is a Medi-Cal managed care benefit that will address clinical and non-clinical needs of high-need, high-cost individuals through the coordination of services and comprehensive care management.

Figure 1. Seven ECM Core Services

ECM will be delivered primarily by community-based ECM Providers that enter into or have existing contracts with MCPs. Providers will be paid according to the specific MCP contract, with a focus on value. ECM Providers may serve one or more of the Populations of Focus with which they have experience and expertise in serving, as well as the services they are proposing to provide to Members. Some of the requirements for ECM providers include:

- Culturally appropriate and timely in-person care management activities
- Formal agreements and processes in place to engage with other entities to coordinate care
- Care management documentation system or process that supports integrated care
- Starting in January 2024 some duals enrolled in D-SNPs for their Medicare coverage will have ECM equivalent care provided by their Medicare Advantage plans as opposed to Medi-Cal MCPs.

[1] Beginning in 2023 in select counties and phasing in statewide by 2026

The implementation of ECM to date has been dynamic with DHCS remaining open to feedback on systems improvement in order to achieve the goal of increasing availability and uptake of ECM and CS for Medi-Cal members. Examples of this work to date include:

- Standardizing eligibility used by Medi-Cal MCPs
- Standardizing referral and authorization processes for Medi-Cal MCPs
- Expanding provider networks and streamlining payment
- Strengthening market awareness
- Improving data exchange

ECM Populations of Focus

ECM is available to specific Populations of Focus. For the purpose of the collaborative, discussion will focus on the following adult ECM Populations of Focus:

- Adults living in the community and at risk of for long term care institutionalization
- Adult nursing facility residents transitioning to the community
- Adults at risk for avoidable hospital or emergency department utilization
- Adults experiencing homelessness
- Adults with serious mental health and/or substance use disorder needs

Eligibility criteria for these Populations of Focus are defined in Appendix 1.

Community Supports

Community Supports (CS), also known as In Lieu of Services, are administered by the Medi-Cal MCPs in order to meet the social needs of Members. These services, which at the option of a Medi-Cal MCP and a Member, can substitute for covered Medi-Cal services as cost-effective alternatives. Providers must have experience and expertise in providing these unique services in a culturally and linguistically appropriate manner. All Medi-Cal MCPs are encouraged to offer as many of the 14 pre-approved Community Supports as possible and are available to eligible Medi-Cal members regardless of whether they qualify for Enhanced Care Management services.

Figure 2. 14 Community Supports Service Categories

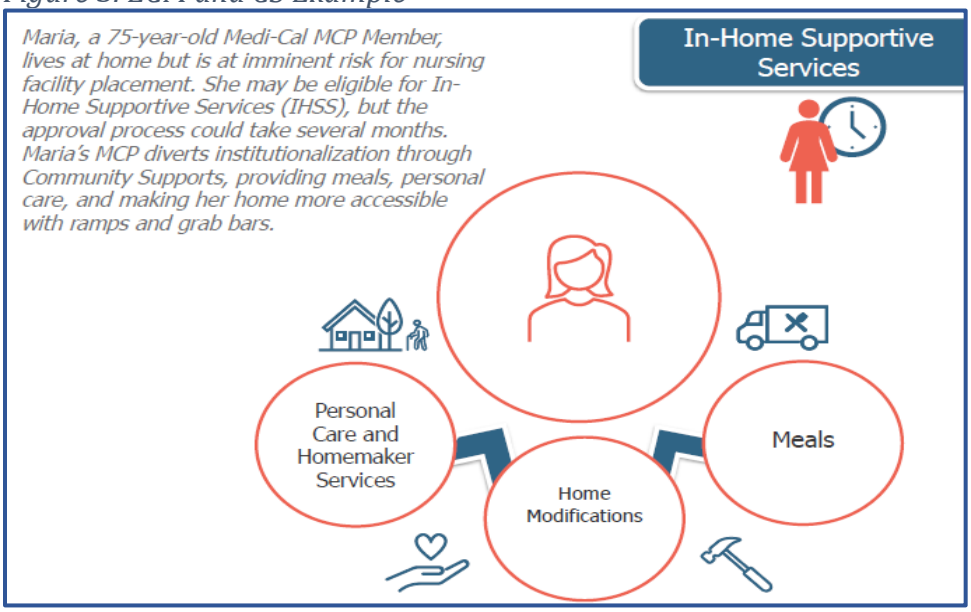
Housing Support	Post-Acute Care Placement	Home-Based Services	Additional Services
•Housing Transition Navigation Services •Housing Deposits •Housing Tenancy and Sustaining Services	•Short-term Post-Hospitalization Housing •Recuperative Care (medical respite) •Nursing Facility Transition/ Diversion to Assisted Living Facilities	•Community Transition Services/Nursing Facility Transition to a Home •Personal Care and Homemaker Services •Environmental Accessibility Adaptations (Home Modifications) •Meals/Medically Tailored Meals	•Day Habilitation Programs •Respite Services •Sobering Centers •Asthma Remediation

Among older adults and persons with disabilities, including those with Alzheimer's Disease and Related Dementias (ADRD) who are at risk of institutionalization and eligible for long-term care are currently living in the community, may be eligible to receive several CS services, including:

- **Nursing facility transition/diversion to assisted living facilities:** Members living at home or in a nursing facility are transferred to an assisted living facility to live in their community and avoid institutionalization in a nursing facility, when possible. Assisted living facilities provide services to establish a community facility residence such as support with daily living activities, medication oversight, and 24-hour onsite direct care staff.
- **Environmental accessibility adaptations (home modifications):** Members receive physical modifications to their home to ensure their health and safety and allow them to function with greater independence. Home modifications can include ramps and grab-bars, doorway widening for members who use a wheelchair, stair lifts, or making bathrooms wheelchair accessible.
- **Respite services:** Short-term relief for caregivers of Members. Members may receive caregiver services in their home or in an approved facility on an hourly, daily, or nightly basis as needed.
- **Personal care and homemaker services:** Members who require assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) receive in-home support such as bathing or feeding, meal preparation, grocery shopping, and accompaniment to medical appointments.
- **Meals/medically tailored meals**: Members receive deliveries of nutritious, prepared meals and healthy groceries to support their health needs. Members also receive vouchers for healthy food and/or nutrition education.

These individuals may be eligible for both ECM and In-Home Supportive Services (IHSS). In such instances, IHSS is primary, and ECM enhances and/or coordinates with IHSS case management, with Medi-Cal MCP ensuring no duplication of services.

Figure 3. ECM and CS Example[2]



[2] Source: ATI Advisory

Other Funding Opportunities for CBOs Serving Older Adults

The CalAIM Incentive Payment Program (IPP) supports the implementation and expansion of Enhanced Care Management (ECM), Community Supports, and other CalAIM initiatives by providing incentives to Medi-Cal managed care plans (MCPs). IPP incentives are oriented around the following priority areas:

- Delivery system infrastructure
- ECM Provider capacity building
- Community Supports Provider capacity building and MCP take-up
- Quality

This is a voluntary program. DHCS does not direct how MCPs spend their earned incentive payments. DHCS anticipates participating MCPs will make strategic investments in, and direct appropriate resources to, ECM and Community Supports Providers, local partners, and other providers. As such, CBOs serving as ECM and CS Providers may benefit from partnering with MCPs to receive such funds.

The Providing Access and Transforming Health (PATH) Capacity and Infrastructure Transition, Expansion and Development (CITED) initiative provides funding to enable the transition, expansion and development of Enhanced Care Management (ECM) and Community Supports capacity and infrastructure. Eligible applicants will be encouraged to coordinate applications with local Managed Care Plans (MCPs) that they contract with or strongly intend to contract with to provide ECM/Community Supports services. Entities who receive CITED funding will be invited to participate in the PATH Collaborative Planning and Implementation initiative, which may be ongoing in their county or region.

Applicants may include, but are not limited to:

- County, city, and local government agencies
- Providers (including but not limited to hospitals and provider organizations)
- Community-Based Organizations (CBOs)
- Medi-Cal Tribal and Designees of Indian Health Programs
- Federally Qualified Health Centers (FQHCs)
- Others as approved by DHCS as part of the application

Applicants must be actively contracted with an MCP, or an MCP's authorized subcontractor or network provider for the provision of ECM or Community Supports or have a signed attestation letter from an MCP or an MCP's authorized subcontractor or network provider that they strongly intend to contract with the Applicant to provide ECM/Community Supports in a timely manner. To date there have been two rounds of funding, with the second round of applications closing May 31, 2023. There has been no announcement about Round 3 funding.

Understanding the "At Risk of Institutionalization/Dementia" Population of Focus and CalAIM Eligibility

The Statewide Learning Collaborative seeks to address the needs of older adult Medi-Cal beneficiaries to are at risk of institutionalization and those with dementia. Most are likely to be dually eligible for both Medicare and Medi-Cal.3 In 2022, there were 1.64 million Californians who

[3] In this paper, dual-eligible enrollees are those individuals who qualify for both Medicare and full Medi-Cal benefits. Accordingly, dual-eligible enrollees must be age 65 and over, or, if under age 65, have been receiving

were dually eligible for Medicare and Medi-Cal. Many of these individuals are older and/or disabled adults. Like all Medicare beneficiaries, dual eligible beneficiaries can choose whether to receive care through Original Medicare or enroll in a Medicare Advantage (MA) plan, sometimes called "Part C" or "MA Plans." In California there are several types of Medicare Advantage; plan options vary by county. For Medi-Cal benefits, most dual eligible beneficiaries are enrolled in Medi-Cal managed care plans. Enrollment in a Medi-Cal managed care plan does not impact Medicare benefits or provider access. Some plans provide integrated care, across both Medicare and Medi-Cal benefits.

Medicare is the primary payer for acute and post-acute care services. Medi-Cal wraps around Medicare by providing assistance with Medicare premiums and cost sharing, and by covering some services that Medicare does not cover, such as long-term services and supports (LTSS). As part of CalAIM, DHCS is implementing policies to promote integrated care for beneficiaries dually eligible for Medicare and Medi-Cal. The dual eligible population will be eligible for some services and programs under CalAIM, including ECM and CS.

Characteristics of the Dual Eligible Population in California

As of 2021, there were 6.5 million Medicare enrollees in California. More than one-fifth (22.4%) or 1.4 million Medicare beneficiaries in California were dual eligibles. Statewide, dual eligibles are nearly equally distributed amount suburban, urban, and rural parts of the state. There are approximately 1.4 million older adults (age 65 and older) who are dually eligible. In California, seven in 10 dual-eligible enrollees are age 65 and over, and nearly six in 10 are female. Populations of color in California are disproportionately more likely to be dually eligible in comparison with the state's total Medicare population. Dual eligible enrollees are also more likely to have limited English proficiency.[4] Of California's dual eligible enrollees, 33% are White, 34% are Asian, 21% are Latinx, and 10% are Black.[5]

Californian Medicare beneficiaries younger than age 65 were more likely than not (54.9%) to be dually eligible for Medi-Cal, while a far smaller share of those age 65–79 (17.3%) and those age 80+ (21.4%) were dually eligible. However, several racial and ethnic groups exceeded those rates. Compared to the 65-through-79 age group overall, Asian beneficiaries (at 32.9%) had almost twice the rate of dual eligibility, and Hispanic beneficiaries (at 48.3%) had almost three times the rate, whereas White beneficiaries (at 10.8%) had a rate just three-fifths the overall rate. Compared to the ages 80+ group overall, Asian beneficiaries (at 61.1%) had almost three times the rate of dual eligibility, Hispanic beneficiaries (at 65.0%) had more than three times the rate, and White beneficiaries (at 12.0%) had just over half the rate. California's urban beneficiaries ages 80 or older were most likely to be dually eligible (21.6%) compared to that age group's rate in other areas. This rate was especially higher than the rate for rural beneficiaries age 80 or older (12.3%). Data tables can be found in Appendix 3.

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disability benefits for 24 months from the Social Security Administration. In order to qualify for Medi-Cal, dual eligible enrollees also must have low incomes (monthly income below 123% of the federal poverty level) and limited assets (below $2,000).

[4] California Health Care Foundation, A Primer on Dual Eligible Californians: https://www.chcf.org/wp-content/uploads/2020/09/PrimerDualEligiblePeopleEnrolledMedicareMediCal.pdf

[5] Source: Public Use File (PUF) of Demographic, Enrollment, Condition Prevalence, Utilization, & Spending (national- & state-level) - Latest Release 2006-2012 MMLEADS Data. Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0 (MMLEADS PUF V2.0) (2006-2012) (09/15/2020) (XLSX). https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics

Defining the Dementia Population in California

National dementia prevalence estimates for those 65 years and older in 2012 have ranged from 8.8% to 10.5% across different Health and Retirement Study (HRS) algorithms, a range which includes the new Harmonized Cognitive Assessment Protocol (HCAP) dementia prevalence estimate of 10% for 2016.[6] The Chicago Health and Aging Project (CHAP) estimates that the prevalence of dementia in California is 12.0% based on 2020 data. The prevalence is higher among individuals age 85 and older (12.7%).[7] For dually eligible beneficiaries age 65 and older in Medicare FFS in California, statewide prevalence of Alzheimer's disease and related dementias was 18.1% (110,551) in March 2021.[8]

Like US-based data, California's Black and Hispanic adults as well as those with lower educational attainment experience a disproportionate burden of dementia.

Prevalence among Medi-Cal only beneficiaries age 65 and older was significantly lower (6.8%) compared to dually eligible beneficiaries (18.1%). Diagnosis is likely underreported among Medi-Cal beneficiaries. Prevalence information based on Medi-Cal data may change for beneficiaries age 50 and older as the full-scope Medi-Cal expansion for that age group.

Among those beneficiaries with Medicaid only, the rates of diagnosis are biased downwards as there have been few incentives to assess for dementia and many against as well as incentives against recording observed diagnoses in electronic health records. Data tables can be found in Appendix 3.

IHSS Recipients as Proxy for At Risk for Institutionalization

The In-Home Supportive Services (IHSS) program provides in-home assistance to eligible aged, blind, and disabled individuals as an alternative to out-of-home care and enables recipients to remain safely in their own homes. There are 724,000 IHSS recipients in California as of June 2023. Of those, more than half (55.6% or 403,000) are age 65 and over. IHSS consists of four programs: Personal Care Services Program (PCSP), Community First Choice Option (CFCO), IHSS Plus Option (IPO), and IHSS-Residual (IR).

Individuals with Alzheimer's and related disorders, including dementia, may be eligible for IHSS. Prevalence of dementia amount IHSS recipients age 65 and older was 28.2%, with wide variation by race/ethnicity, and by county. Prevalence among Medi-Cal beneficiaries aged 65 and older with a Skilled Nursing Facility (SNF) stay was 70.1%.9 Other factors driving risk for institutionalization may include comorbid physical and behavioral health conditions and social and economic factors. Data tables can be found in Appendix 3.

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[6] Manly JJ, Jones RN, Langa KM, et al. Estimating the Prevalence of Dementia and Mild Cognitive Impairment in the US: The 2016 Health and Retirement Study Harmonized Cognitive Assessment Protocol Project. JAMA Neurol. 2022;79(12):1242–1249. doi:10.1001/jamaneurol.2022.3543

[7] Dhana K, Beck T, Desai P, Wilson RS, Evans DA, Rajan KB. Prevalence of Alzheimer's disease dementia in the 50 US states and 3142 counties: A population estimate using the 2020 bridged-race postcensal from the National Center for Health Statistics. Alzheimer's Dement. 2023;1-8. https://doi.org/10.1002/alz.13081

[8] Diagnosis data for dually eligible beneficiaries enrolled in any type of Medicare Advantage is not currently available to the Department of Health Care Services, and therefore that population is not included in this workbook. Approximately 43% of dually eligible beneficiaries were in any type of Medicare Advantage in 2021.

[9] Skilled Nursing Facility stays may be paid for by Medicare and/or Medi-Cal, based on the length of the stay.

Appendices

Appendix 1: Enhanced Care Management Population of Focus Eligibility Criteria[10]

Adults Living in the Community and At Risk for LTC Institutionalization

Adults who:

(1) Are living in the community who meet the SNF Level of Care (LOC) criteria; OR who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury;

AND

(2) Are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring);

AND

(3) Are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).

Adults At Risk for Avoidable Hospital or Emergency Department Utilization

Adults who meet one or more of the following conditions:

(1) Five or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence;

(2) Three or more unplanned hospital and/or short-term skilled nursing facility (SNF) stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

Adult Nursing Facility Residents Transitioning to the Community

Adult nursing facility residents who:

(1) Are interested in moving out of the institution;

AND

(2) Are likely candidates to do so successfully;

AND

(3) Are able to reside continuously in the community.

Adults with Serious Mental Health and/or SUD Needs

Adults who:

(1) Meet the eligibility criteria for participation in, or obtaining services through:

(i) SMHS delivered by MHPs;

[10] DHCS ECM Policy Guide: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

(ii) The Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program;

AND

(2) Are experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, high measure (four or more) of ACEs based on screening, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms;

AND

(3) Meet one or more of the following criteria:

(i) Are at high risk for institutionalization, overdose, and/or suicide;

(ii) Use crisis services, EDs, urgent care, or inpatient stays as the primary source of care;

(iii) experienced two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months;

(iv) are pregnant or postpartum (12 months from delivery).

Individuals Experiencing Homelessness

Adults (whether or not they have dependent children/youth living with them) who:

(1) Are experiencing homelessness, defined as meeting one or more of the following conditions:

(i) Lacking a fixed, regular, and adequate nighttime residence;

(ii) Having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(iii) Living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);

(iv) Exiting an institution into homelessness (regardless of length of stay in the institution);

(v) Will imminently lose housing in next 30 days;

(vi) Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence;

AND

(2) Have at least one complex physical, behavioral, or developmental need, with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.

Appendix 2: Current Programs and Services for Older Adults

In-Home Supportive Services (IHSS)

The In-Home Supportive Services (IHSS) program provides in-home assistance to eligible aged, blind, and disabled individuals as an alternative to out-of-home care and enables recipients to remain safely in their own homes. IHSS is by far the largest Medi-Cal LTSS program with over 650,000 recipients and is expected to grow over time. IHSS remains carved out of Medi-Cal managed care; however, CalAIM offers some opportunities to increase coordination of IHSS through such programs as ECM and CS.

Home and Community-Based Services (HCBS) Waivers

California operates six Home and Community-Based Services (HCBS) Waiver programs. These programs assist Medi-Cal eligible individuals with services they need to live at home or in the community instead of living in a hospital or long-term care facility. An individual can only be enrolled in one waiver at a time. HCBS Waiver services include case management, community transition services, private duty nursing, family training, home health aides, life-sustaining utility reimbursement, habilitation services, respite care, and other services required to maintain the health and safety of eligible participants in the community setting of their choice. Among the HCBS Waivers are the Multipurpose Senior Services Program (MSSP) Waiver and the Assisted Living Waiver (ALW).

Multipurpose Senior Services Program (MSSP) Waiver

The Multipurpose Senior Services Program (MSSP) Waiver provides social and health care management services to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement. While most of the program participants also receive IHSS, MSSP provides on-going care coordination, links participants to other needed community services and resources, coordinates with health care providers, and purchases needed services and items with the goal to prevent or delay institutionalization. The current waiver is set to expire June 30, 2024, with plans to eliminate the program as a standalone waiver.

Assisted Living Waiver (ALW)

The Assisted Living Waiver (ALW) is a Medi-Cal program that pays for assisted living, care coordination, and other benefits provided to eligible seniors and persons with disabilities who qualify for placement in a nursing facility but are willing to live in an assisted living setting. The waiver is currently set to expire February 28, 2024. Services are provided to individuals living in a Residential Care Facility for the Elderly (RCFE) or by a licensed Home Health Agency in public subsidized housing. Individuals living in an ALW facility setting are required to pay for their own room and board.

Community-Based Adult Services (CBAS) (formerly Adult Day Health Care)

The CBAS program can help people get out-of-home help during the day. CBAS offers daytime health and social services at centers throughout California. CBAS is available for older adults and adults with disabilities who would otherwise qualify for nursing facility care or have chronic conditions that meet entrance criteria as determined by the Medi-Cal MCP (e.g., dementia or mental health diagnosis). CBAS is a Medi-Cal Managed Care benefit available to eligible Medi-Cal beneficiaries enrolled in Medi-Cal Managed Care. Eligibility to participate in CBAS is determined by the

beneficiary's Medi-Cal MCP. CBAS was included in California's Section 1115(a) Medicaid Waiver, entitled Medi-Cal 2020; CBAS will continue under CalAIM.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) model of care provides a comprehensive medical/social service delivery system using an interdisciplinary team approach in a PACE Center that provides and coordinates all needed preventive, primary, acute and long-term care services. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model allows eligible individuals to remain independent and in their homes for as long as possible. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by the Department of Health Care Services, and be able to live safely in their home or community at the time of enrollment. PACE is a separate, licensed health plan and a basic requirement of PACE plans is to provide enhanced care management so people who enroll in PACE programs should already receive ECM. PACE is paid for by Medi-Cal and Medicare. Eligible individuals will enroll in a PACE or Medicare HMO but cannot enroll in both. PACE is carved out of Medi-Cal managed care.

California Community Transitions (CCT) Program

The CCT helps people move out of medical facilities and into the community. Federal funding for the CCT program has been extended through January 1, 2027. Individuals who are Medi-Cal eligible and have been in a medical facility for at least one day can receive assistance in coordinating discharge and services with the CCT program.

Health Homes Program (HHP) and Whole Person Care (WPC) Pilots

Starting January 1, 2022, Medi-Cal managed care enrollees receiving care management through the Health Homes Programs (HHP) or Whole Person Care (WPC) Pilots meeting the ECM population of focus (POF) criteria transitioned to ECM and CS. Eligible individuals are those in high risk/high utilizer groups including those with multiple chronic conditions and frequent and often costly medical needs. Under CalAIM, Medi-Cal MCPs will administer mandatory care coordination through ECM and optional CS services will be provided to eligible members statewide.

Other Programs Serving Individuals with Dementia

Various other programs serve older Californians, including those with dementia, regardless of Medi-Cal eligibility. These programs will continue unchanged alongside CalAIM programs.

Area Agencies on Aging coordinate a variety of services for older adults, adults with disabilities, informal caregivers, and family caregivers.

The *Family Caregiver Services* program addresses the unique needs of family members who provide care to a relative. The available services include arranging for respite care and providing training to caregivers and other family members.

California Caregiver Resource Centers (CRCs) offer help to thousands of families and caregivers of those with Alzheimer's disease and other disorders. CRCs provide the following services to families and caregivers at low or no cost:

- Specialized information and referral
- Family consultation and care planning
- Respite care
- Short-term counseling

- Support groups
- Professional training
- Legal and financial consultation
- Education

Meals on Wheels is a weekly home-delivered meal program available to persons 60 years of age or older, regardless of income, who are homebound because of illness, disability, or have difficulty obtaining food or meals for themselves.

Figure 4. Medi-Cal LTSS Programs[11]

Program	Responsible Entity	Eligibility Criteria	Enrollment
AIDS Waiver	Department of Public Health	▪ Written diagnosis of HIV/AIDS ▪ Health status appropriate for home care ▪ Meets the nursing facility level of care or higher	1,500* participants were served by 20 providers across 26 counties
Assisted Living Waiver	Department of Health Care Services (DHCS)	▪ Age 21 or older ▪ Qualifies for nursing facility level of care but able to reside in a lower-level care setting	4,685 enrollees across 15 counties
California Community Transitions Program (Money Follows the Person)	DHCS	▪ Has resided in a hospital or nursing facility for at least 90 days ▪ Continues to require the level of care provided in an institution ▪ Desires to leave the institution and live in the community	4,282 enrollees transitioned from 2008 - 2018
Community-Based Adult Services	Department of Aging (CDA)	▪ Meets or exceeds nursing facility level of care or: • Diagnosed brain injury and/or chronic mental disorder • Moderate or severe cognitive disorder • Mild cognitive disorder requiring assistance • Developmental disability	38,304 enrollees across 27 counties
Health Homes Program	DHCS	▪ Meets chronic condition criteria ▪ Meets acuity/complexity criteria	14,300 enrollees across 12 counties
Home and Community-Based Alternatives	DHCS	▪ Qualifies for nursing facility level of care ▪ Lives in a hospital or nursing facility or is at risk of institutionalization within 30 days ▪ Can safely receive required care in the home or setting of choice	4,688 enrollees across 51 participating counties

[11]Source: California Health Care Foundation – https://www.chcf.org/publication/medi-cal-managed-care-long-term-services-supports-opportunities-considerations-under-calaim/

*Most recent publicly available data from 2016

†*Regional centers* are community-based, nonprofit agencies that serve individuals with developmental disabilities

‡*High-risk/high utilizer* groups include enrollees who have prevalence of multiple complex chronic conditions and have frequent and often costly medical needs, and individual waivers and pilots have distinct criteria to distinguish a target population

Program	Responsible Entity	Eligibility Criteria	Enrollment
Home and Community-Based Services for the Developmentally Disabled	Department of Developmental Services	▪ Qualifies for nursing facility level of care ▪ Developmentally disabled ▪ Regional Center consumer†	By December 31, 2022, up to 150,000 individuals are projected to be served by 21 regional centers throughout the state
In-Home Supportive Services	Department of Social Services	▪ Be age 65 and older *or* ▪ Disabled *or* ▪ Blind *and* ▪ Live at home or a residence of their own choosing	630,792 recipients received services from 570,404 providers across the state.
Multipurpose Senior Services Program (MSSP)	CDA	▪ Age 65 and older ▪ Qualifies for nursing facility level of care ▪ Can be served within MSSP's cost limitations	10,464 enrollees across 46 counties where the waiver services are available
Program of All-Inclusive Care for the Elderly	DHCS	▪ Age 55 and older ▪ Resides in a PACE service area ▪ Qualifies for nursing facility level of care ▪ Able to live safely in their home or community at the time of enrollment	Average of 9,816 enrollees per month across 15 counties
Whole Person Care Pilots	DHCS	▪ High-risk/high utilizer‡ as defined by individual pilots	161,231 enrollees across 28 counties

Appendix 3: Data Tables

Table 1. Dual Eligibility Rate by Geography (percent of Medicare beneficiaries)[12]

Jurisdiction	Rural	Suburban	Urban	Overall
CA	18.8%	24.2%	22.4%	22.4%
U.S.	18.8%	17.8%	18.0%	18.0%

Table 2. Dual Eligibility Rate by Age and Geography in CA (percent of Medicare beneficiaries)[13]

Geography	Under 65	65-79	80 and up	Overall
Rural	56.0%	13.1%	12.3%	18.8%
Suburban	59.4%	17.7%	18.6%	24.2%
Urban	54.7%	17.4%	21.6%	22.4%
Statewide	54.9%	17.3%	21.4%	22.4%

Table 3. Medicare-Medicaid Enrollment by Type and Sex[14]

	Female	Male
Full Benefit	58.0%	42.0%
Partial Benefit	58.9%	41.1%
Medicare Only	53.1%	46.9%
Medicaid Only (Disability)	47.6%	52.4%

Table 4. Dual Eligibility Rate by Race/Ethnicity and Age in CA (percent of Medicare beneficiaries)[15]

Age	Asian	Black	Hispanic	Other/Unknown	White	Overall
Under 65	55.0%	68.2%	68.1%	47.9%	48.7%	54.9%
65-79	32.9%	24.0%	48.3%	17.5%	10.8%	17.3%
80 and up	61.1%	21.5%	65.0%	25.9%	12.0%	21.4%
Overall	40.7%	33.9%	55.2%	21.6%	14.7%	22.4%

Table 5. Dual Eligibility Rate by Race/Ethnicity and Geography in CA (percent of Medicare beneficiaries)[16]

Geography	Asian	Black	Hispanic	Other/Unknown	White	Overall
Rural	40.8%	39.2%	54.3%	25.2%	17.0%	18.8%
Suburban	39.2%	39.7%	58.2%	27.7%	20.4%	24.2%
Urban	40.7%	33.8%	55.1%	21.5%	14.4%	22.4%
Statewide	40.7%	33.9%	55.2%	21.6%	14.7%	22.4%

[12] DHCS report - https://www.dhcs.ca.gov/services/Documents/OMII-Medicare-Databook.pdf
[13] Ibid.
[14] Source: Public Use File (PUF) of Demographic, Enrollment, Condition Prevalence, Utilization, & Spending (national- & state-level) - Latest Release 2006-2012 MMLEADS Data. Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0 (MMLEADS PUF V2.0) (2006-2012) (09/15/2020) (XLSX). https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics
[15] Source: DHCS report - https://www.dhcs.ca.gov/services/Documents/OMII-Medicare-Databook.pdf
[16] Ibid

Table 6. Prevalence of AD dementia among adults ≥65 years in California[17]

Number of people age 65 years and older, in thousands	Calculated estimates	
	Prevalence, % (95% CI)	Number (95% CI) of people with AD, in thousands
5976.2	12.0 (11.1, 13.0)	719.7 (665.0, 774.4)

Table 7. State- and County-Level Dual Status Codes, June 2022[18]

Geography of Beneficiary	Qualified Medicare Beneficiaries (QMB)-only	QMB plus Full Medicaid Benefits	Specified Low-income Medicare Beneficiaries (SLMB)-only	SLMB plus Full Medicaid Benefits	Qualified Disabled and Working Individuals (QDWI)	Qualifying Individuals (QI)	Other Dual Full Medicaid Benefit	Total
California	17,770	1,417,421	6,813	293	-	5,901	194,890	1,643,088
Alameda	581	59,288	214	11	0	258	4,402	64,754
Alpine	*	31	0	0	0	0	*	31
Amador	16	1,115	*	*	0	12	248	1,391
Butte	78	9,158	42	*	0	40	1,588	10,906
Calaveras	16	1,545	12	0	0	14	248	1,835
Colusa	*	1,006	*	0	0	*	173	1,179
Contra Costa	325	31,119	123	17	0	106	3,195	34,885
Del Norte	27	1,598	13	*	0	*	203	1,841
El Dorado	46	4,353	28	*	0	16	763	5,206
Fresno	336	41,244	146	*	0	103	4,046	45,875
Glenn	*	1,332	*	0	0	*	255	1,587
Humboldt	76	5,927	25	*	0	36	1,208	7,272
Imperial	121	14,284	38	*	0	48	1,023	15,514
Inyo	*	625	12	*	0	*	154	791
Kern	364	32,434	197	*	0	182	5,391	38,568
Kings	47	4,954	16	*	0	15	598	5,630
Lake	15	4,354	14	*	0	19	861	5,263
Lassen	13	981	*	0	0	*	175	1,169
Los Angeles	7,429	452,816	2,010	97	*	1,674	49,026	513,052
Madera	57	5,191	20	0	0	17	911	6,196
Marin	56	4,546	24	*	0	14	1,068	5,708
Mariposa	*	677	*	*	0	*	181	858
Mendocino	36	4,947	17	0	0	13	943	5,956
Merced	90	11,161	43	*	0	26	1,614	12,934
Modoc	12	525	*	0	0	*	98	635
Mono	*	179	*	0	0	*	52	231
Monterey	159	11,613	57	*	0	46	2,986	14,861
Napa	38	3,782	17	*	0	14	1,180	5,031
Nevada	28	2,844	25	*	0	11	754	3,662
Orange	1,053	99,208	448	29	0	387	12,431	113,556
Placer	95	7,947	47	*	0	48	1,038	9,175
Plumas	*	873	*	0	0	*	223	1,096
Riverside	897	69,740	562	29	0	455	17,236	88,919
Sacramento	530	60,630	252	20	0	228	9,927	71,587
San Benito	18	1,546	*	0	0	*	296	1,860

[17] Dhana, Klodian, Todd Beck, Pankaja Desai, Robert S. Wilson, Denis A. Evans, and Kumar B. Rajan. "Prevalence of Alzheimer's disease dementia in the 50 US states and 3142 counties: A population estimate using the 2020 bridged-race postcensal from the National Center for Health Statistics." Alzheimer s & Dementia Early View (2023).

[18] Source: MMCO Statistical & Analytic Reports, Enrollment Snapshots (National, State, and County), Quarterly Release 6/205-6/2022. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics

Geography of Beneficiary	Qualified Medicare Beneficiaries (QMB)-only	QMB plus Full Medicaid Benefits	Specified Low-income Medicare Beneficiaries (SLMB)-only	SLMB plus Full Medicaid Benefits	Qualified Disabled and Working Individuals (QDWI)	Qualifying Individuals (QI)	Other Dual Full Medicaid Benefit	Total
San Bernardino	861	75,320	445	22	0	415	12,244	89,307
San Diego	1,703	95,476	717	40	0	557	15,267	113,760
San Francisco	190	48,365	101	12	0	69	3,862	52,599
San Joaquin	299	27,000	147	*	0	137	3,081	30,664
San Luis Obispo	73	6,805	42	*	0	39	1,530	8,489
San Mateo	155	16,351	46	*	0	62	2,645	19,259
Santa Barbara	123	11,933	61	*	0	64	2,054	14,235
Santa Clara	476	57,766	181	16	0	165	5,835	64,439
Santa Cruz	91	7,273	37	*	0	41	1,640	9,082
Shasta	88	9,162	46	*	0	40	1,704	11,040
Sierra	*	130	0	0	0	*	30	160
Siskiyou	23	2,566	19	*	0	17	455	3,080
Solano	109	12,807	64	*	0	39	2,489	15,508
Sonoma	107	11,535	69	*	0	61	3,241	15,013
Stanislaus	254	19,586	128	*	0	114	4,199	24,281
Sutter	35	4,579	16	*	0	15	647	5,292
Tehama	37	3,271	21	*	0	13	629	3,971
Trinity	*	658	*	0	0	*	144	802
Tulare	206	19,408	83	*	0	88	3,322	23,107
Tuolumne	16	2,006	*	*	0	*	402	2,424
Ventura	265	22,176	141	*	0	136	3,751	26,469
Yolo	64	5,996	26	*	0	36	724	6,846
Yuba	36	3,546	21	*	0	11	482	4,096

Table 8. Dual Eligibility by County[19]

County	Dually Eligible Medicare Beneficiaries (and % of County Total)		Medicare-Only (Non-Dual) Medicare Beneficiaries (and % of County Total)		Total Medicare Beneficiaries
Alameda	53,835	22.2%	188,862	77.8%	242,697
Alpine	39	14.6%	229	85.4%	268
Amador	1,230	10.4%	10,598	89.6%	11,828
Butte	9,835	21.8%	35,354	78.2%	45,189
Calaveras	1,574	11.7%	11,920	88.3%	13,494
Colusa	1,039	27.7%	2,714	72.3%	3,753
Contra Costa	28,968	14.4%	172,220	85.6%	201,188
Del Norte	1,640	25.9%	4,694	74.1%	6,334
El Dorado	4,623	10.0%	41,708	90.0%	46,331
Fresno	38,362	27.2%	102,728	72.8%	141,090
Glenn	1,473	25.6%	4,278	74.4%	5,751
Humboldt	6,593	22.4%	22,850	77.6%	29,443
Imperial	13,857	44.0%	17,637	56.0%	31,494
Inyo	707	15.6%	3,817	84.4%	4,524
Kern	33,161	27.7%	86,441	72.3%	119,602
Kings	5,022	28.4%	12,658	71.6%	17,680
Lake	4,748	27.6%	12,433	72.4%	17,181
Lassen	1,074	20.7%	4,108	79.3%	5,182
Los Angeles	447,757	30.0%	1,044,774	70.0%	1,492,531
Madera	5,409	21.8%	19,351	78.2%	24,760
Marin	5,073	8.5%	54,770	91.5%	59,843

[19] Source: DHCS report - https://www.dhcs.ca.gov/services/Documents/OMII-Medicare-Databook.pdf

County	Dually Eligible Medicare Beneficiaries (and % of County Total)		Medicare-Only (Non-Dual) Medicare Beneficiaries (and % of County Total)		Total Medicare Beneficiaries
Mariposa	740	15.0%	4,195	85.0%	4,935
Mendocino	5,327	23.0%	17,872	77.0%	23,199
Merced	11,643	31.1%	25,812	68.9%	37,455
Modoc	560	21.7%	2,018	78.3%	2,578
Mono	213	10.3%	1,863	89.7%	2,076
Monterey	13,342	19.9%	53,689	80.1%	67,031
Napa	4,684	15.7%	25,210	84.3%	29,894
Nevada	3,238	10.8%	26,808	89.2%	30,046
Orange	102,679	19.7%	419,626	80.3%	522,305
Placer	7,526	8.6%	79,728	91.4%	87,254
Plumas	1,016	15.9%	5,371	84.1%	6,387
Riverside	75,066	19.5%	309,421	80.5%	384,487
Sacramento	58,497	22.8%	198,096	77.2%	256,593
San Benito	1,622	17.4%	7,683	82.6%	9,305
San Bernardino	76,503	25.4%	225,174	74.6%	301,677
San Diego	93,711	17.4%	445,228	82.6%	538,939
San Francisco	46,689	32.0%	99,097	68.0%	145,786
San Joaquin	25,028	22.4%	86,485	77.6%	111,513
San Luis Obispo	7,578	11.4%	58,797	88.6%	66,375
San Mateo	17,103	13.3%	111,335	86.7%	128,438
Santa Barbara	12,359	15.9%	65,471	84.1%	77,830
Santa Clara	54,983	20.4%	215,031	79.6%	270,014
Santa Cruz	8,275	15.7%	44,350	84.3%	52,625
Shasta	10,142	21.3%	37,377	78.7%	47,519
Sierra	167	18.4%	741	81.6%	908
Siskiyou	2,786	20.3%	10,905	79.7%	13,691
Solano	13,648	16.7%	68,032	83.3%	81,680
Sonoma	13,316	12.3%	95,252	87.7%	108,568
Stanislaus	21,078	24.3%	65,561	75.7%	86,639
Sutter	4,506	25.9%	12,923	74.1%	17,429
Tehama	3,598	24.0%	11,420	76.0%	15,018
Trinity	735	20.9%	2,786	79.1%	3,521
Tulare	20,502	32.4%	42,740	67.6%	63,242
Tuolumne	2,128	13.3%	13,929	86.7%	16,057
Ventura	23,875	15.4%	130,991	84.6%	154,866
Yolo	6,044	18.6%	26,519	81.4%	32,563
Yuba	3,532	27.5%	9,328	72.5%	12,860
Grand Total	**1,420,458**	**22.4%**	**4,911,008**	**77.6%**	**6,331,466**

Table 9. Prevalence of Alzheimer's Disease and Related Dementias Among California Medi-Cal Beneficiaries, March 2021[20]

Age	With Alzheimer's/ Dementia	Total Dual Beneficiaries Age 30 and older in Medicare FFS	Prevalence
Age 30 and older	122,007	805,456	15.1%
Ages 30-64	11,456	196,056	5.8%
Age 65 and older	110,551	609,400	18.1%

Table 10. Percent of Duals, Medicaid, Medicare enrollment with Alzheimer's disease and ADRD in CA (2022)[21]

Medicare-Medicaid Enrollment Type	Enrollees with Alzheimer's disease	Enrollees with Alzheimer's and related disorders
Full Benefit	6.78%	15.60%
Partial Benefit	1.89%	5.31%
Medicare Only	3.76%	8.44%
Medicaid Only (Disability)	*	0.61%

Table 11. Monthly IHSS Recipients by Program Type, California, June 2023[22]

IHSS Program	Recipients in PCSP	Recipients in CFCO	Recipients in IPO	Recipients in IHSS-R
Recipients	331,916	357,871	19,616	12,613

Table 12. Monthly IHSS Recipients by Age, California, June 2023[23]

Age Group	0-17 Age Group (Minors) Recipients	18-44 Age Group Recipients	45 to 64 Age Group Recipients	65 to 74 Age Group Recipients	75 to 84 Age Group Recipients	85+ Age Group Recipients	Total Recipients
Recipients	66,157	104,779	150,439	150,119	147,755	105,281	724,530

[20] Source: https://www.dhcs.ca.gov/Documents/Prevalence-of-Alzheimers-Disease-and-Related-Dementias.pdf

[21] Source: "PUF_2012" tab in *Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) Public Use File (PUF) Version 2.0 (2006–2012) (02/2019) (XLSX)*, CMS, "MMCO Statistical & Analytic Reports."

[22] Source: IHSS Program Data, June 2023. https://www.cdss.ca.gov/inforesources/ihss/program-data

[23] Ibid.

Table 13. Medi-Cal Beneficiaries Age 30 and Older Receiving IHSS, with Alzheimer's and Related Dementias by Age[24,25]

Age	With Alzheimer's/ Dementia	Medi-Cal Beneficiaries Age 30 and Older Receiving IHSS	Prevalence
Age 30 and older	72,967	370,190	19.7%
Ages 30-64	7,458	137,995	5.4%
Age 65 and older	65,509	232,195	28.2%

Table 14. Medi-Cal Beneficiaries Age 30 and Older Receiving IHSS, with Alzheimer's and Related Dementias by Race and Ethnicity[26]

Race/Ethnicity	With Alzheimer's/ Dementia	Medi-Cal Beneficiaries Age 30 and Older Receiving IHSS	Prevalence
All Race/Ethnicity	72,967	370,190	19.7%
White	26,844	126,518	21.2%
Hispanic	16,957	87,016	19.5%
Black	5,009	54,984	9.1%
Asian	18,385	74,997	24.5%
Native Hawaiian/ Other PI	2,057	9,644	21.3%
American Indian/ Alaska Native	205	1,837	11.2%
Other	1,815	9,878	18.4%
Unknown	1,695	5,316	31.9%

[24] Source: https://www.dhcs.ca.gov/Documents/Prevalence-of-Alzheimers-Disease-and-Related-Dementias.pdf
[25] Note: Includes dually eligible beneficiaries in Medicare FFS and Medi-Cal only beneficiaries but not dually eligible beneficiaries in any type of Medicare Advantage.
[26] Source: https://www.dhcs.ca.gov/Documents/Prevalence-of-Alzheimers-Disease-and-Related-Dementias.pdf